MARION COUNTY SCHOOLS

Permission for School Administration of Medication

For school use only:
□ Routine
□ PRN (As needed)
Start Date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing physician's signature (for prescription medications), and provided to the school in the original labeled container for all medications. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider. It is the responsibility of the parent to furnish all medications to be administered at school. No medications will be provided by the school district or school district employees to students.

_____ Child's Name	_____ Date of Birth
_____ Name of School	_____ Grade

Medication:		Dosage:
Purpose of Medication:		Route:
Time medication to be given at school (Lunch times vary (10:30a – 1p)	Frequency (e.g., daily)	Note special storage requirements ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ ____ weeks ☐ ____ days		Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies.) Is this medication a controlled substance? ☐No ☐Yes
Possible Side Effects:		

_____ Prescribing Health Care Provider's Signature (for prescription medications)	_____ Date
Stamp, Print or Type Health Care Provider's Name & Address:	Office Phone Number Office Fax Number

Section below to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the above medication as ordered. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription (if applicable) to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this "Permission for Medication" to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I agree the school district and its employees and agents are not liable for an injury arising from administration of medication authorized by an IHP. I agree that I shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP. I understand that I am responsible for notifying the school if my child's medications change in any way. I understand that in the absence of the school nurse, the school administrator may designate a trained school employee to assist students with medications.

_____ Signature of Parent / Guardian	_____ Date
_____ Print or Type Name of Parent / Guardian	_____ Day Phone Number

Marion School District